HEALTH INSURANCE PREMIUM PAYMENT PROGRAM
APPLICATION

1. **Please fill out your name and address**

Your Name and Address	Social Security Number - - Telephone Number ( ) _____ (home) ( ) _____ (work)

2. **Please complete the following information regarding your employment, or the employment of the parent offering the group health plan.**

Your Employer's Name and Address	Employee Benefits Manager (if available) _____ Telephone Number ( ) _____

3. **Employee's name and SSN # (if different from your own).** _____ _____

4. **Please complete the following information regarding your insurance. If you have more than one plan, please list.**

Insurance Company _____	**Insurance Company** _____
Name of Plan _____	**Name of Plan** _____

5. **List all persons eligible for coverage under this policy.**

Name	Date of birth	Relationship	Medicaid Covered	Applied
			yes ☐ no ☐	
			yes ☐ no ☐	
			yes ☐ no ☐	
			yes ☐ no ☐	
			yes ☐ no ☐	

Signature: _____ **Date Completed:** _____

for DSS use only		
	Case ID Number _____ **New Case** ☐ **Redetermination** ☐	**Worker ID#** _____ **Program Designation** _____ **Court-Ordered Absent Parent Case** _____ **Major Illnesses** yes ☐ no ☐

INSTRUCTIONS FOR COMPLETING THE APPLICATION

Please complete the application on the opposite page. Mail it in, along with the Medical History Questionnaire and a copy of your insurance card, if available, to the address on the previous page, or use the pre-addressed postage paid envelope supplied by your case worker.

Question 1. Please list your name, address, social security number and telephone number. Print clearly.

Question 2. List the name and address of the employer offering the group health plan. If known, list the name of the contact person for additional information about your policy. Include the company's phone number.

Question 3. If the insurance is through a parent or person other than yourself, please list the employee's name and social security #. Do not include court-ordered absent parent cases.

Question 4. Your employer may offer more than one health plan. List all insurance companies that offer plans through your employer. Include the specific name of your plan (Key Advantage, Health Service, etc.) if it has one.

Question 5. List the name and date of birth of everyone in your family eligible for the health plan, and whether they receive Medicaid. Check "Applied" if any of these has applied for Medicaid and is waiting for a decision.

Signature: Your eligibility worker should fill out the section "for DSS use only". Sign and date the application form at the bottom.

IMPORTANT

Remember: You do not need to be currently enrolled in a group health plan for DMAS to consider paying your premiums.